

Blue Cross Blue Shield of Vermont and The Vermont Health Plan Prior Approval Form

SSRI and SNRI Anti-depressants

Lexapro®, Effexor XR®, Paxil CR™, Prozac Weekly™, and Cymbalta®

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met BCBSVT/TVHP will authorize coverage of a Brand Selective Serotonin Reuptake Inhibitor and a Serotonin Norepinephrine Reuptake Inhibitor. Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____

BCBSVT/TVHP Member ID#: _____ Date of birth: _____

Provider Name: _____ Provider Phone number: _____

Provider Fax number: _____ PCP Name: _____

Indicate which agent is being requested:	
Lexapro® PREFERRED	<input type="checkbox"/>
Effexor XR® PREFERRED	<input type="checkbox"/>
Cymbalta®	<input type="checkbox"/>
Paxil CR™	<input type="checkbox"/>
Prozac Weekly™	<input type="checkbox"/>

INDICATIONS FOR USE	YES	NO
1) Patient has failed a 30 day trial of Fluoxetine, Paroxetine, Citalopram, or Sertraline: a) If No: Please explain why not AND attach Clinical Notes from Patient's Records _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

CONTRAINDICATIONS FOR USE	YES	NO
1. Is Patient currently taking a Monoamine Oxidase Inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does Patient has existing Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is patient Breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.



**BlueCross BlueShield
of Vermont**
Independent Licensees of the Blue Cross and Blue Shield Association.

